

medicaid and the uninsured

MARCH 2012

Medicaid and Community Health Centers: the Relationship between Coverage for Adults and Primary Care Capacity in Medically Underserved Communities

Executive Summary

Community health centers play an important role in providing care to uninsured and low-income individuals living in medically underserved communities. They rely on many different revenue sources and, over time, Medicaid has become a central source of funding for most health centers. To better understand how Medicaid influences health center practice, this paper compares the strength of health centers in states that have expanded Medicaid coverage for adults to health centers in states with more limited Medicaid coverage for adults. Differences between the two groups of health centers help shed light on the implications of broader Medicaid coverage for low-income populations on the overall strength of health care safety net.

Health centers in expansion states had more patient care sites and saw more patients than health centers in more limited states. In 2009, health centers in expansion states averaged eight sites per health center grantee, compared to five sites per health center grantee in more limited states. The additional patient care sites enabled health centers in expansion states to care for more patients, serving 4.5 million patients versus 3.7 million patients at health centers in more limited states. In addition, from 2005-2009, health centers in expansion states experienced a greater growth in the number of patients served, compared to those in more limited states.

Health centers in expansion states received more total revenue and a greater proportion of revenue from Medicaid than health centers in more limited states. In 2009, health centers in expansion states received revenues of nearly \$3 billion, averaging \$655 per patient, while health centers in more limited states received \$1.8 billion in revenues, averaging \$500 per patient. This payment difference may reflect coverage for a broader set of services and higher payment rates in states that have expanded Medicaid eligibility.

Health centers in expansion states employ more medical staff, across almost all specialties, than health centers in more limited states. Health centers in expansion states employ, on average, twice as many clinicians as health centers in more limited states. They also had better patient-to-clinician ratios across all specialties, which often means shorter wait times and better access to care for patients in the community. In addition, from 2005-2009, health centers in expansion states hired more staff, except nurse practitioners, than health centers in more limited states.

In sum, broader Medicaid eligibility for adults appears to be associated with an enhanced ability of health centers to invest in capacity-building activities to better meet the needs of their patients and communities. These findings support the value of expanded Medicaid eligibility for improving patient access to health care services and are relevant to the implementation of the Affordable Care Act's Medicaid expansion in 2014.

Introduction

Community health centers (known for Medicare and Medicaid coverage and payment purposes as federally qualified health centers (FQHCs)) play an important role in providing care to uninsured and low-income individuals living in medically underserved communities. As with any medical practice, having adequate and stable funding is critical to enabling health centers to supply the range of services and staffing to meet the needs of the communities they serve. However, for health centers, which are required by law to serve the entire community regardless of one's ability to pay and, therefore, treat large numbers of uninsured patients, securing funds sufficient to sustain operations can be challenging.

Health centers, like other providers, rely on many different revenue sources, but, over time, Medicaid has become a central source of funding for most health centers. Federal law requires that all state Medicaid programs cover health center services for eligible beneficiaries and pay for all Medicaid covered services furnished by health centers using a prospective payment system linked to patient care costs. This requirement means that Medicaid payments received by health centers for the covered services they provide to program beneficiaries relate to the cost of that care. This ensures that funding from other sources can be used to support care for uninsured patients. Of particular importance to increasing health centers' revenues are states' Medicaid eligibility standards, because of their impact on coverage of and payment for the services provided by health centers. Health centers operating in states with more expansive Medicaid eligibility levels are likely to have a greater percentage of their patients covered by Medicaid, which, in turn, means more revenue available to support health center operations.

From a financial perspective, state Medicaid eligibility and coverage policies for adults have the potential to exert a major influence on total health center revenues and, therefore, on their overall structure and operations, not only for Medicaid patients, but for all patients. To understand how Medicaid influences health center practice, this paper uses a number of measures to compare the strength of health centers in states that have expanded Medicaid coverage for adults to those in states with more limited Medicaid coverage for adults. These measures focus on patient volume and growth, staffing, and overall financial strength. Differences between the two groups of health centers help shed light on the implications of broader Medicaid coverage for low-income populations on the overall strength of the health care safety net and its ability to create new access points for all residents of a community.

Background

Community health centers were created to deliver comprehensive primary health care to people in high need, low resource areas. Health centers were established through Section 330 of the Public Health Service Act, which specifies the legal requirements of the program.¹ These standards, in turn, determine which entities may be FQHCs for Medicare and Medicaid coverage and payment purposes. To qualify as a health center, an entity must meet four basic requirements: (i) location in or service to medically underserved populations and communities; (ii) provision of comprehensive primary health care in accordance with federal guidelines; (iii) prospective adjustment of charges in accordance with patients' ability to pay; and (iv) governance by a board of

¹ There are approximately 100 additional health center "look-alikes" that are identified by HRSA and certified by CMS as meeting the health center criteria but do not receive Section 330 funding.

directors, a majority of whose members must be patients of the health center.² Health centers that meet these standards are eligible for federal Section 330 grants to support care for the uninsured, as well as special coverage and payment rules under Medicare and Medicaid. As of 2010, 1,124 federally funded health centers, in more than 8,100 locations, were operating in every state, the District of Columbia, and the U.S. territories. An additional 100 “look-alike” FQHCs that do not receive federal health center grants but meet all health center requirements, and thus qualify for Medicare and Medicaid’s special coverage and payment rules, were also in operation that year.

Health centers differ widely in structure and operation, reflecting the unique circumstances of the communities they serve, differences in patient care needs and preferences, differences in local health system characteristics, and variations in state laws and policies. Health centers located in rural areas may be smaller, may rely more heavily on staffing by nurse practitioners and physician assistants, and may offer a more limited range of services. While, health centers operating in more populous urban areas may be larger, may operate in multiple fixed sites and temporary locations (e.g., a mobile van), and may offer a broad range of medical, dental, behavioral, and other health services all under one roof.

State laws and policies influence health center formation and operations in a number of ways. For example, in the District of Columbia and the 23 states that have broad state nurse practice acts, clinical staff might include more nurse practitioners.³ State laws that license health clinics, as well as local zoning laws, can also influence both the scope of services offered by health centers and their service locations.

State Medicaid coverage and payment policies, in particular, have a major impact on health center structure and operations. Federal Medicaid law requires that all state programs cover health center services for categorically needy beneficiaries and that they pay for these services using a cost-related prospective payment system linked to patient care costs.⁴ Within these broad parameters, state coverage and payment vary in terms of which classes of ambulatory care services are covered, which procedures are recognized as payable, which clinical and administrative costs are allowable, and which standards are used to calculate actual payment amounts.

States also vary in the scope of their Medicaid coverage for low-income individuals. Through Medicaid and the Children’s Health Insurance Program (CHIP), states cover most children with family incomes up to 200% of the federal poverty level (FPL); however, the eligibility levels for the parents of these children are often much lower. States are required to cover parents with dependent children up to the welfare eligibility levels of July 1996, which vary by states, but are often below 50% of the FPL. Several states have expanded coverage for parents above these levels, although many have not. As a result, the number and income status of individuals eligible for Medicaid varies greatly by state. This paper will take a look at how the insurance status of low-income individuals affects the health centers, a place where many go to access care.

² 42 USCS § 254b.

³ Kaiser Commission on Medicaid and the Uninsured. *Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants*. March 2011. Available at: (<http://www.kff.org/medicaid/8167.cfm>).

⁴ 42 U.S.C. §1396(bb).

Methods

To identify which health centers to include in the analysis, we first divided states into two groups. The first consists of states that have expanded Medicaid eligibility levels for parents above the minimum levels, referred to as expansion states. The second reflects states that have not raised eligibility levels for parents above the minimum standards, referred to as more limited states. Using data on state Medicaid eligibility levels in 2009 from Statehealthfacts.org, we identified 12 states with Medicaid eligibility standards for parents that were equal to or surpassed 100% of the Federal Poverty Level (FPL) (\$10,830 for an individual, \$18,310 for a family of three in 2009). The median financial eligibility level in expansion states was 191% of the FPL. More limited states were defined as those with financial Medicaid eligibility standards for parents that were less than 100% of the FPL. We selected the 13 states with the lowest eligibility thresholds that did not offer other coverage to parents. The median financial eligibility level in more limited states was 44% of the FPL (Table 1).

Table 1: Medicaid Eligibility Standards for Parents, 2009			
Expansion States		More Limited States	
<u>State</u>	<u>Eligibility (% of FPL)</u>	<u>State</u>	<u>Eligibility (% of FPL)</u>
Arizona	106%	Alabama	24%
Connecticut	191%	Georgia	50%
Delaware	120%	Kansas	32%
Hawaii	100%	Louisiana	25%
Illinois	191%	Mississippi	44%
Maine	200%	Montana	56%
Minnesota	215%	Nebraska	58%
New Jersey	200%	New Hampshire	49%
New York	150%	North Carolina	49%
Rhode Island	181%	South Dakota	52%
Vermont	191%	Texas	26%
Wisconsin	200%	Virginia	29%
		West Virginia	33%

Several states and health centers were excluded from this analysis. States that had significantly changed their eligibility standards over the past five years were excluded. In addition, states were excluded from the more limited eligibility group if they provided any Medicaid or state-funded coverage, even if the coverage was more limited than Medicaid, to individuals with incomes above the parent eligibility thresholds. Finally, look-alike health centers in the selected states also were excluded because they are not required to provide UDS data to HRSA.

Uniform Data System (UDS) data for the operating health centers in selected states were obtained from the Health Resources and Services Administration (HRSA). UDS data include annual reports on patient demographics, staffing and utilization, clinical performance, and financial information from all health center grantees that receive Section 330 awards. This data was used to examine the health center operations. A total of 220 health centers in expansion states and 299 in more limited states were included in the analysis.

The demographic characteristics of the patients utilizing the health centers included in the analysis were similar across the two groups of states. In 2009, approximately 6 in 10 FQHC patients were nonelderly adults (between the ages of 19-64) and female. Seven in 10 patients had incomes at or below 100% of the FPL in both expansion and more limited states. Only the racial and ethnic composition of patients differed—health center patients in expansion states were less likely to be White than those in more limited states (27% of patients at health centers in expansion states compared to 38% of patients in more limited states). (See Appendix A for additional patient characteristics.)

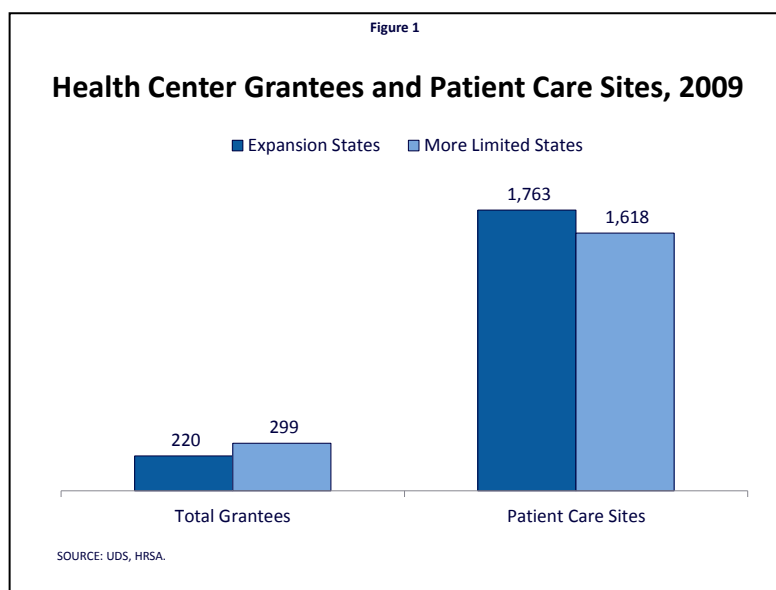
One key difference between the health centers in the two groups of states is that health centers in expansion states were more likely to be defined in the UDS as urban health centers compared to health centers in more limited states. To ensure that any differences between health centers in the two groups of states on the key measures in the analysis were not explained by these urban/rural differences, we performed a separate analysis comparing urban health centers in expansion states to urban health centers in more limited states and rural health centers in expansion states to rural health centers in more limited states. The findings of this separate analysis were consistent with the overall findings, suggesting that the more urban nature of health centers in expansion states is not a major driver of the differences between the two groups of health centers.

Findings

Health Center Capacity and Patients

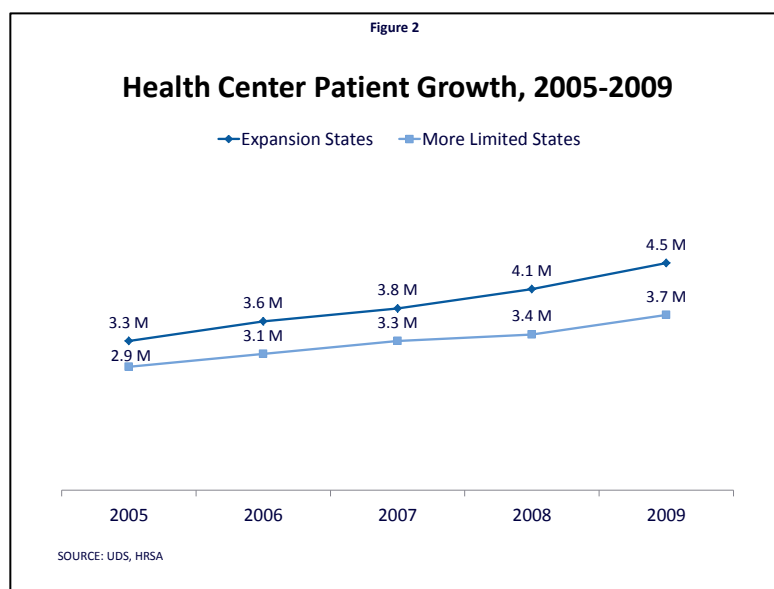
Despite the fewer number of total grantees, health centers in expansion states had more patient care sites and saw more patients than health centers in more limited states (Figure 1).

Most health centers receiving federal grants operate multiple patient care sites as a way to expand access to care within their service areas. In 2009, the 220 health centers in expansion states established 1,763 patient care sites for an average of eight sites per health center grantee. In comparison, the 299 health centers in more limited states had 1,618 patient care sites, for an average of five sites per health center grantee.

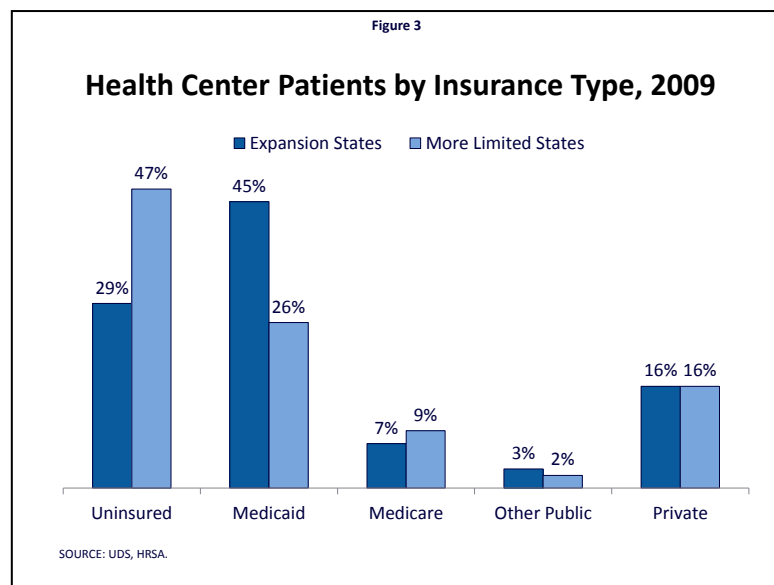


The additional patient care sites enabled health centers in expansion states to care for a greater number of patients than those in more limited states. Health centers in expansion states saw a total of 4.5 million patients, or about 2,500 patients per site, while health centers in more limited states saw a total of 3.7 million patients, or about 2,300 patients per site.

Health centers in expansion states experienced greater growth in the number of patients served compared to health centers in more limited states (Figure 2). While both groups of health centers experienced significant growth in the number of patients served from 2005 to 2009, the growth in total patients was somewhat stronger among health centers in expansion states. Expansion state health centers experienced a 37% growth in total patients over the four-year period. During the same time period, health centers in more limited states saw a 28% growth in patients.

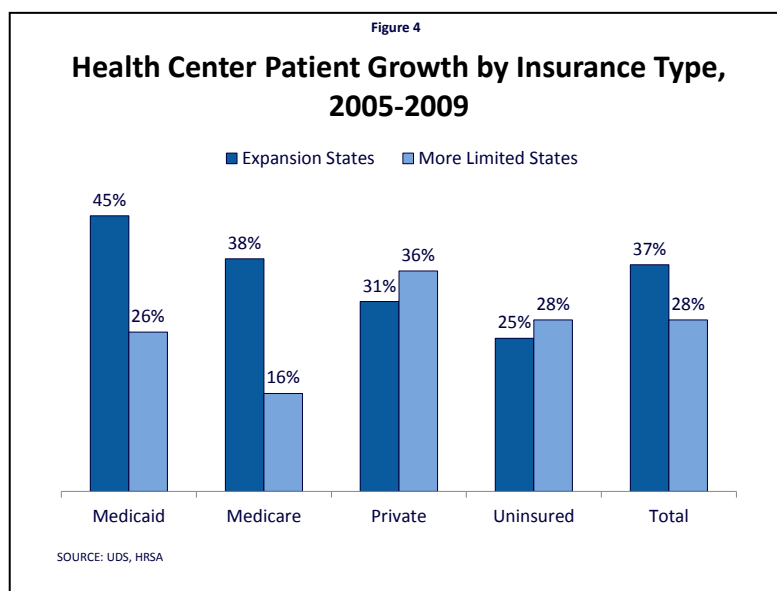


Patients served by health centers in expansion states were more likely to have Medicaid coverage and less likely to be uninsured than those served by health centers in more limited states (Figure 3). Health insurance coverage among patients differed dramatically in expansion and more limited states. In 2009, 45% of patients at health centers in expansion states were covered by Medicaid, compared to just 26% of patients at health centers in more limited states. Likewise, in expansion states, the proportion of all health center patients who were uninsured was 29%. While this figure represents a very high number of uninsured patients, it was far lower – 18 percentage points lower – than the 47% of patients who were uninsured in more limited states. This finding demonstrates the importance of Medicaid in covering low-income health center patients and underscores the extent to which broader Medicaid coverage, while associated with a reduction in the number of uninsured low income patients, nonetheless does not eliminate health centers’ major role in treating the uninsured.



The contrast in health insurance coverage among patients in the two groups of states is even starker for adult health center patients, where the differences in Medicaid eligibility levels are more substantial. Nearly one-third of adults seen by health centers in expansion states were covered by Medicaid, compared to only 12% of adults at health centers in more limited states. Similarly, over half (56%) of adult patients at FQHCs in more limited states were uninsured, compared to only 36% of adults at health centers in expansion states.

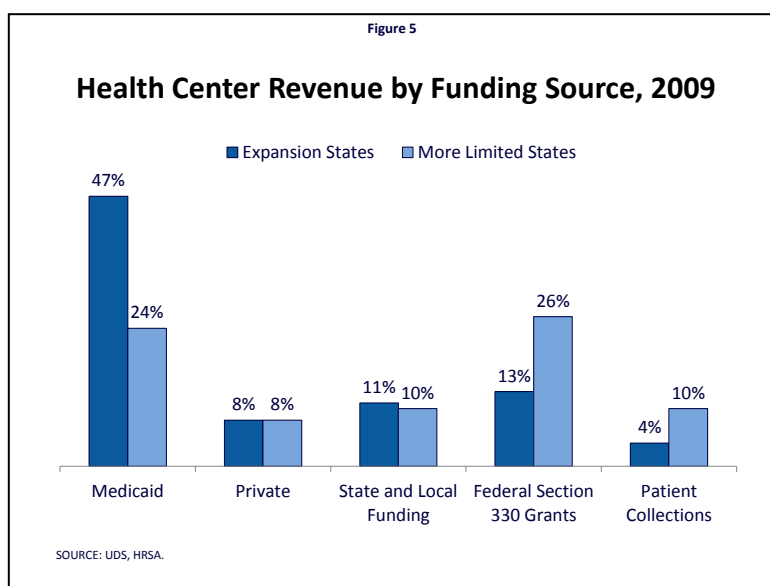
Health centers in expansion states experienced a greater increase in Medicaid patients, while health centers in more limited states saw a larger rise in privately insured patients (Figure 4). From 2005-2009, health centers in expansion states experienced a 45% increase in the number of Medicaid patients compared to only 26% growth at health centers in more limited states. The rise in Medicaid patients in both groups of health centers is not surprising because they operate in medically underserved communities with few primary health care providers.



While health centers in both groups of states saw growth in the number of uninsured and privately-insured patients, health centers in more limited states experienced a slightly greater growth in privately-insured patients, compared to expansion states. The growth in privately-insured patients among both groups of health centers may reflect the fact that, as patient cost-sharing has increased over the past decade, low-income privately-insured patients have experienced growing difficulties in finding private providers that are willing to adjust their out-of-pocket payments. This is something health centers are obligated to do under their sliding fee schedule requirements. However, because per-patient revenues received by health centers for their privately insured patients are significantly below levels paid for Medicaid patients, the losses that health centers must absorb from private insurance are far higher; between 1997 and 2005, health centers reported a cumulative shortfall of \$3.8 billion from private payers.⁵ These revenue shortfalls are a particular challenge for health centers in more limited states that also treat larger numbers of uninsured patients.

Health Center Funding

Health centers in expansion states received more total revenue and a greater proportion of revenue from Medicaid than health centers in more limited states (Figure 5). In 2009, health centers in expansion states had revenues of nearly \$3 billion, averaging \$655 per patient, while more limited states received \$1.8 billion in revenues, for an average of \$500 per patient. This amounts to a 24% difference in total revenue. Not surprisingly, health centers in expansion states received nearly half of their revenue from Medicaid, far eclipsing revenues from other sources. In



⁵ Shin, P. et al. (February 2008). *Health Centers: An Overview and Analysis of Their Experience with Private Health Insurance*. Kaiser Family Foundation. Available at: (<http://www.kff.org/uninsured/upload/7738.pdf>).

contrast, health centers in more limited states received only a quarter of their revenue from Medicaid, and were equally reliant on federal Section 330 grants.

Health centers in expansion states also received more revenue on a per-patient basis from all sources, than health centers in more limited states. In 2009, Medicaid payments per-patient were \$682 for FQHCs in expansion states, compared to only \$475 for health centers in more limited states. This payment difference may reflect lower patient care costs for health centers in more limited states, but also likely indicates coverage for a broader set of ambulatory care services and higher payment rates in states that have expanded Medicaid eligibility. Although Section 330 grants comprised a smaller proportion of overall revenues for health centers in expansion states, these health centers received more funding per uninsured patient (\$291) than health centers in more limited states (\$276). This may reflect more comprehensive programs and services developed by these health centers.

Health Center Staffing and Access to Care

Health centers in expansion states employ more medical staff, across almost all specialties, than health centers in more limited states. The greater resources available to health centers in expansion states enabled these health centers to employ, on average, twice as many clinicians to provide direct patient care as health centers in more limited states. While the total number of primary care physicians was similar across the two groups, health centers in expansion states employed nearly twice as many pediatricians and dentists, two and a half times as many OB/GYNs, and four times as many psychiatrists (Table 2).⁶

Table 2: Staff Profiles of Health Centers in Expansion States and More Limited States, 2009		
Medical Specialty	Health Centers in Expansion States	Health Centers in More Limited States
Primary Care Physicians	1,490	1,139
OB/GYNs	330	136
Pediatricians	569	288
Dentists	671	389
Psychiatrists	109	28
Nurse Practitioners	755	805
Physician Assistants	377	342
Certified Nurse Midwives	178	57

* All numbers are calculated based on the full-time equivalent (FTE)

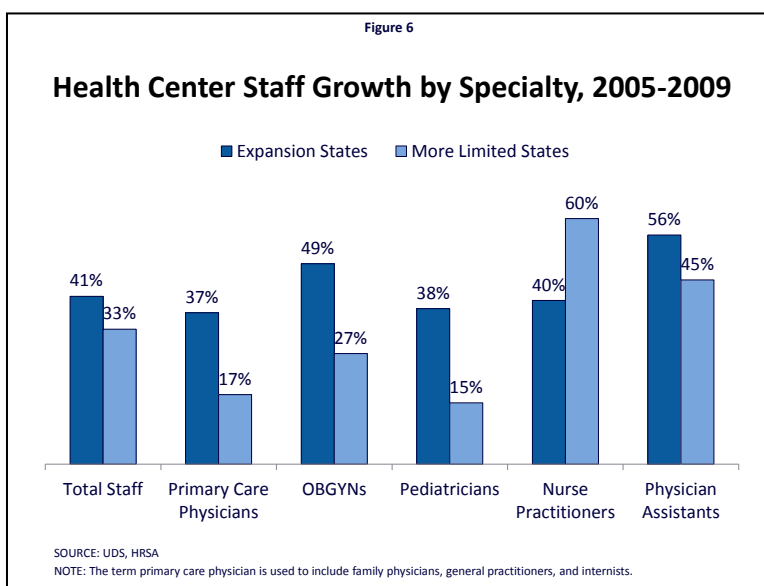
Health centers in more limited states were more reliant on non-physician clinicians, including nurse practitioners and physician assistants. These health professionals can provide similar levels of care to physicians but are less expensive to employ. In 2009, health centers in more limited states employed more nurse practitioners and similar numbers of physician assistants compared to those in expansion states.

⁶ The term primary care physician is used in this paper to include family physicians, general practitioners, and internists.

Health centers in expansion states have better patient-to-clinician ratios, across all specialties measured, than health centers in more limited states. Lower patient-to-clinician ratios often mean shorter wait times for appointments and better access to care. In 2009, the overall patient-to-physician ratio was 1,743 for health centers in expansion states and 2,344 for health centers in more limited states. Access to specialized physicians, including pediatricians and OB/GYNs, was worse for health center patients in more limited states. The child-to-pediatrician ratio was 2,769 for health centers in expansion states and 4,025 for health centers in more limited states, while the women-to-OB/GYN ratio was 3,959 for health centers in expansion states and 7,566 for health centers in more limited states. The high OB/GYN ratios in both limited and expansion states may reflect several factors, including the tendency of health centers to rely on family practice physicians for OB/GYN services because of the difficulty in recruiting OB/GYN specialists.

Importantly, for access to care for health center patients in more limited states, when nurse practitioners, physician assistants, and certified nurse midwives were included in the measure, the patient-to-clinician ratio improved for health centers in more limited states to 1,331, although it was still higher than the ratio for health centers in expansion states (1,154).

From 2005-2009, health centers in expansion states hired more staff, except nurse practitioners, than health centers in more limited states (Figure 6). Total staff growth for health centers in expansion states increased 41% from 2005-2009, while the staff at health centers in more limited states increased 33% over the same time period. Health centers in expansion states invested more heavily in physician hiring, increasing primary care physicians and pediatricians by over a third and OB/GYNs by nearly half. Health centers across the states hired more nurse practitioners and physician assistants, though the increase in the number of nurse practitioners was greatest at health centers in more limited states.



Discussion

As the above findings highlight, expansive Medicaid eligibility levels for adults are associated with several important health center characteristics. Because they receive more Medicaid revenue, health centers in expansion states are able to invest in more patient capacity through a greater number of locations and higher staffing levels. They are also able to offer a greater range of specialized care and services, including oral and behavioral health services, that are frequently in short supply in medically underserved communities. Previous studies have shown that health centers do not distinguish between their insured and uninsured patients in the

range and level of care they provide.⁷ Thus, as health centers invest their greater revenues in capacity-building activities, they appear better positioned to meet the needs of their patients and communities. The benefits of stronger operational capacity impact both insured and uninsured health center patients and translate into improved access to care for all those living in medically underserved communities.

These findings support the value of expanded Medicaid eligibility for improving access to care and on enhancing health center capacity. Both of these findings hold particular relevance to the implementation of the Affordable Care Act (ACA). Beginning in 2014, the ACA will expand Medicaid eligibility to all adults and children with incomes up to 138% of the FPL, extending coverage to an anticipated 16 million adults. Another 16 million people will likely obtain private coverage through state-based health insurance exchanges. Many of those expected to gain coverage are currently health center patients, and they will be able to continue to rely on health centers as their primary source of care.

To provide health centers with additional resources to expand capacity in preparation for these coverage expansions, the ACA increased the health center trust fund through fiscal year 2015. However, after 2015, the added trust fund resources end, which means that health centers must be able to support their expanded operations through Section 330 operating grants and revenues received from public and private health insurance payments. The high poverty levels of current health center patients mean that, while health centers will play a key role as primary care providers in qualified health plans offered through state health insurance exchanges, they can be expected to continue as major providers of health care for Medicaid patients. In this regard, it is the Medicaid eligibility that, over the long term, will determine the sustainability of the initial health center expansion and that will enable health centers to grow to meet the needs of their medically underserved communities. This growth, in turn, will aid not only the newly insured Medicaid patients who receive care through health centers, but also those with private insurance and those who remain uninsured.

This issue paper was prepared by Peter Shin and Sara Rosenbaum with data support from Brian Bruen and Alice (Xiao-Xiao) Lu at the School of Public Health and Health Services, George Washington University and Rachel Arguello and Jennifer Tolbert with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. Additional support for this issue paper was provided by the RCHN Community Health Foundation.

⁷ Gusmano M.K., Fairbrother, G., and Park, H. Exploring the limits of the safety net: Community health centers and care for the uninsured. *Health Affairs*, 2002; 21: 6188-194.

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

This publication (#8293) is available on the Kaiser Family Foundation's website at www.kff.org.



The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.